Food Security of the Homeless in Delhi

A study of the nutritional status and dietary intakes of adult homeless persons in New Delhi

Working Paper:
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Introduction

"Shetty Chauhan, 60, died on the night of 12 January near a busy traffic roundabout in central Delhi…He had been ill with a heavy cold for eight days...his wife Kamla explained that he had stopped eating and drinking tea prior to his death".

-BBC News, January 14, 2010

A conservative estimate of one per cent of Delhi's population – 1.5 lakh adults and children – constitute one of the most vulnerable categories of the urban poor, the homeless. Even as January 2010 recorded some of the lowest temperatures, the death toll of homeless persons in Delhi battling the extreme temperature rose to twenty. What needs to be highlighted is that scientific evidence points toward malnutrition and hunger as the underlying causes which make people susceptible to extreme weather conditions[1].

Taking account of this alarming situation of hunger deaths of the homeless, the Commissioners to the Supreme Court in the Right to Food case recommended that wholesome hot cooked meals be provided to the homeless populations at subsidized prices. For the same, the Delhi government was advised to set up 500 community kitchens where affordable nutritious food is available and a further 100 kitchens which serve free food to the destitute"[2]

In this context, then, it is significant to enquire into the situation of food security of the homeless populations in Delhi. This study aims to identify the nutritional status and dietary intake of different categories of homeless populations in Delhi. The findings of the study are aimed at establishing the need for community kitchens for the homeless in Delhi as also recommendations based on the findings for how this model should be organized.

Food security of urban homeless populations

Urban homeless – the most marginalized category even within the urban poor populations – constitute, anywhere between 100 million and one billion of the global population (UNCHS, 1996). This broad range is the consequence of the many variant definitions of what constitutes a 'homeless' person – a person with no shelter whatsoever; one with shelter that is very insecure (e.g. squatter settlements); one with shelter that is temporary (including pavement dwellers and refugee camps).

Homelessness, as the term suggests, refers to the lack of adequate and secure shelter for a person. The official definition for homelessness in India lies in the Census of India definition which refers to 'houseless

[1] A report of the World Health Organisation (WHO) on Nutritional Needs in Emergencies states, "A cold environment increases an individual's energy expenditure—especially if shelter, clothing and/or heating are inadequate. Current convention uses an average temperature of 20ºC as a base, adding an allowance of 100 kcal for every 5º below 20ºC as shown in the box below:

[2] Letter of Commissioners of Supreme Court in the case: PUCL v. UOI & Ors. Writ Petition (Civil) no. 196 of 2001 to the Registrar, Supreme Court, dated January 25th 2010

people' as the persons who are not living in 'census houses'. The latter refers to 'a structure with roof', hence the enumerators are instructed by Census officials 'to take note of the possible places where the houseless population is likely to live, such as on the roadside, pavements, drainage pipes, under staircases, or in the open, temple-mandaps, platforms and the like'(Census of India, 1991: 64).

Being rendered houseless, further implies that mostly these populations are unable to even cook and organize food for themselves, and are therefore exposed to a higher risk of food insecurity and deprivation. Conversely, research on food security mostly uses traditional survey instruments to measure household level food security, thus systematically invisibilising the lived experiences of food insecurity of individual and often scattered homeless populations. Therefore, it becomes significant to examine what methods and indicators may be used to examine the extent of food insecurity among the homeless.

Campbell (1991) defines food insecurity essentially as a limitation or uncertainty with respect to:

1) The availability of nutritionally adequate, safe foods and/or
2) The ability to acquire personally acceptable foods in socially acceptable ways

Accordingly, indicators need to be developed in order to measure the following four essential aspects of food insecurity:

(i) the quantitative availability of food (energy sufficiency),
(ii) the qualitative aspects concerning the types and diversity of food (nutritional adequacy),
(iii) the psychological acceptability (feelings of deprivation, restricted choice, anxiety related to the quality or quantity of available food) and
(iv) the social acceptability of consumption patterns, (meal frequency, composition, methods of food acquisition such as growing or purchasing rather than begging, scrounging or stealing) (Campbell, 1991)

"I always smell the food before eating it. If it smells sour I don't eat it" **(a 16 year old in Nizamuddin)**

The most commonly used indicators to measure food insecurity are direct observation of physiological symptoms of food deprivation. This is usually done through anthropometric measurements such as height/age, weight/height, upper arm circumference and body mass index. Further, indicators such as nutrient intake data, and data on nutrition related illness or injury (such as anemia or goiter), are used to measure physiological food deprivation (Barrett, 2002).

However, health is the product of many factors and not just nutrient intake and energy sufficiency and most of the above indicators focus on only either of the two. Therefore, more recent literature on food insecurity point towards examination of coping strategies of people in the face of risk of food insecurity, which is likely to point toward the dimensions of psychological and social acceptability as well. Coping strategies may range from sale of assets, reducing food consumption and energy expenditure, to foraging, theft (Barrett,

2002) and dependence on food charities. Thus, an examination of the proportion of income spent on accessing food as well as the sources used to access food (e.g. cooking/purchasing/begging) will further point toward how psychological and social dimensions play a role. The examination of all of these indicators together is likely to give a holistic picture of the extent of food insecurity.

Within this holistic framework of food insecurity, it is significant to examine and document the prevalence of food insecurity among homeless populations in Delhi. While significant studies have been conducted in the recent past pointing toward the prevalence and lived experience of homeless populations in Delhi, very little is known about the extent of food insecurity, specifically through an examination of nutritional status of the homeless. Civil society groups such as Ashray Adhikar Abhiyan (2000) and Indo Global Social Service Society (2010) conducted extensive surveys with homeless populations in Delhi with an objective to enumerate the homeless as also capture their perceptions and lived experiences on a broad basis. A more recent Planning Commission study conducted by the Centre for Equity Studies – Living Rough: Surviving City Streets (2008) attempted to capture the lived experience of homelessness in four cities of India including Delhi. Among examining different aspects of homeless such as livelihood and income, reasons for homelessness, sanitation and education, the study examined their access to food. However, a significant limitation of the study was a relatively small sample size due to which the findings of the survey were merely indicative of certain trends and no generalizations could be made on these findings (Delhi City Report in Living Rough, 2008). Furthermore, the sample had a low proportion of young earning male adults who otherwise form more than 50% of the urban homeless population in Delhi (IGSSS, 2009). This category of young earning single male adults within the homeless is also especially important for a variety of reasons – the young single earning male send savings home, engaged in casual physical labour that demands a greater degree of physical fitness and desire to exit homelessness from previous anecdotal accounts.

> ***"Not everyone on the street is an addict or a beggar. But public perception tends towards such biases. The reason for such misconceptions is that the visibility of such persons on the streets is high. Others, who form the majority, work and as such we do not take notice of them. The painter, who is called for white washing work, might be a homeless. The rickshaw puller that everyone sees might be homeless. Many fruits and vegetable sellers are also homeless."***
>
> **- Report on the Assessment of Permanent Shelters in New Delhi (2009)**

Most significantly, while all of the above studies point toward the lived experiences of food insecurity of individual persons, none record the actual prevalence of food insecurity and under-nutrition, among the homeless. Similarly little is known about the quality of diets available to homeless persons or their anthropometric status.

This study, therefore, seeks to strengthen the findings already established by the above previous studies, by taking a larger and more representative sample size as also the use of anthropometric indicators.

Aim

To study the nutritional status, quality of diet of homeless population in New Delhi within the overall context of their food security.

Objectives

1. To estimate the nutrition status of homeless populations (men, women and children) using anthropometric measures
2. To describe the diet of homeless populations
3. To identify the source of food for homeless populations
4. To estimate the proportion of daily income homeless populations spend on accessing food

Methodology

Primary data was collected in February 2010 through a survey of 190 homeless adults at Nizamuddin and Okhla. Both these areas in South Delhi, have an evidently large proportion of homeless populations (IGSSS, 2009) possibly due to reasons such as greater availability of casual labour employment (nearby industrial areas), availability of food charities at nearby religious places such as Nizamuddin dargah, Sai Mandir at Lodi Road. Furthermore, most of the migrants have a preference to stay within the vicinity of one's own community e.g. Nizamuddin area in Delhi is known for a major proportion of Muslims, due to which even recent Muslim migrants prefer to stay in the same area. The Okhla flyover, on the other hand, has a large proportion of migrants from Rajasthan and the same pattern is seen here as well. These two areas were specifically selected for the study, since it is also the primary field area of the Dil Se campaign work with the homeless, with whom the Centre for Equity Studies is closely associated.

In Nizamuddin area, primary data was collected at the Aman Health clinic[3], at MCD parks inhabited by homeless families and two night shelters for the homeless- one managed by an NGO Ashray Adikar Abhiyan (AAA) and another managed by the MCD Slum Department. Both the shelters are paid for shelters where users are to pay Rs. 6 for a twelve hour period. However, during winters (generally until end of February), both these shelters are run free of cost and no user charges are taken. The AAA shelter is a temporary tent like structure with separate sections for men and women, while the MCD shelter is a concrete structure, with a large hall for males, and a small adjacent room meant for females. Both shelters almost have the same set of rules although the MCD shelters are more strict about not allowing substance abusers into the shelter. Furthermore, some homeless have a misconception that the MCD shelter charges a fee while the AAA shelter is run free, even though both are run free for homeless during winters. It needs to be therefore accounted that since these shelters were run free during the time of survey, even homeless persons with a lesser income inhabited these shelters.

[3] The Aman Health clinic, is an initiative of the Dil Se Campaign, specifically focused on providing free medical aid to homeless populations.

In Okhla, primary data was collected under the Modi Mill flyover where a large population of homeless families were found.

Along with a BMI measure, a questionnaire was administered pertaining to dietary intake of the respondents, proportion of expenditure on food, source of food as well as earnings was collected through 24 hours recall. A nutritionist assisted in analyzing the quality of the dietary intake of the respondents. Height of the respondents was measured in centimeters and weight measured through a digital weighting machine (in kilograms).

Profile of respondents

The study attempted to take response from a sample of 100 males and 100 females. However there were particular difficulties in getting female respondents. Therefore, most of the male respondents of the study were single men while more female respondents were women who lived along with families The study thus had 72 female respondents and 118 male respondents which totals up as 190 respondents. The average age of the adult respondents was 36 years with 35 years being the average age of the male respondents and 36 years for the female respondents.

Of the total respondents, 29 respondents were mobilized from the community where the Aman health clinic was located and came to the clinic for the survey[4]. There were 14 respondents from the AAA shelter, Nizamuddin; 27 male respondents from the MCD Shelter, Nizamuddin; 66 respondents from 3 parks and streets around the Nizamuddin area and 54 respondents at Okhla under the Modi Mill flyover. The MCD shelter in spite of having a separate room for women had no women taking shelter there. This could be due to the absence of women staff in the shelter and the consequent vulnerability that such a situation might lead to.

> ***"I just want regular work. Delhi govt has done a good job providing these shelters"* – a person in the night shelter**

With respect to AAA and MCD shelters, field investigators[5] noted that there was not much significant difference with respect to profile of population, except for the fact that there is a likelihood of more number of substance abusers to be found in the AAA shelter.

Most respondents found at both the shelters – both male and female – were single migrants. While few were pilgrims, most were single and working. Most of the single working migrants were headloaders, rickshaw pullers, construction workers.

[4] However, none of the respondents for the survey were patients seeking medical aid. Instead, the clinic was only used as a space to conduct the survey where homeless persons were specifically requested to come for the survey

[5] Field investigators refer to the Dil Se campaign team members who assisted in the data collection for this survey. Many of their observations with respect to profile of respondents are recorded verbatim in this study, considering that they have worked with homeless respondents consistently since the past five years.

Field investigators remarked that most of the women found on the streets are single (widowed or separated or unmarried). Many of the single working women were involved in ragpicking, while other destitute and inform women depended on begging at the Nizamuddin dargah.

Many of the families found at Nizamuddin were migrants from Purnia and Kathiar districts of Bihar. Many migrated after loss of livelihood in a natural disaster (such as the recent Kosi flood). Some other families were forced to live on the streets after their slums in the nearby Viklang Basti were destroyed. At Okhla, most of the families are migrants from Rajasthan.

Field investigators remarked from their close interactions with the homeless populations in these areas that most of the respondents of the survey were homeless since almost the past ten to fifteen years. Even those found at shelters had been permanent users at the shelters since years and had still not found more permanent means of accommodation.

The respondents could be said to be living in the most vulnerable situation, vulnerability as defined and categorized by the 10th Five Year Plan (housing, economic, social and personal)[6]. A majority of the respondents also form the floating population group, earning their daily wages and sending money home. Within the respondents there were people who could stay in the night shelter – single working men and who could not – women who found it uncomfortable to stay in the shelter and also those with families who prefer to stay in the streets. The latter were found in the various parks (in Nizamuddin) and under the flyover (in Okhla).

Limitations of the Study

In the community situation and absence of natural light it was difficult to observe anemia and hence was dropped after initial few respondents were observed. Also computing cost for cooked food, though was part of the study had to be discarded later as it was difficult for the respondent to compute the cost per person and most respondents cooking their meals had families and therefore could give the cost of the ingredients bought for a few days (i.e. neither monthly nor daily). The survey attempted to take the response of 100 men and 100 women, the number of women however became less due to the fact that the survey took place in the evenings with a view that people would be back to their shelters after the day's work. However as women were more often than men, busy with the evening chores of cooking and cleaning it was difficult to get women to be a part of the survey. Thus one needs to specifically build a different strategy to include women to be a part of the study.

[6] As quoted in the draft PHRN Book 16: Urban Health (forthcoming).

Data and Findings

a) Accessing food: Source and expenditure

The source of the dietary intake was also recorded along with dietary recall. The sources were grouped under:

1) Purchased food- The respondents depending on buying cooked meals
2) Purchased and charity –The respondents depending on buying cooked meals and charity food for sustenance
3) Purchased and cooked- The respondents who buy cooked meals as well as buy ingredients and cooked at their own chulha
4) Cooked- The respondent who cooked at their own chulha
5) Cooked and charity- The respondents who cooked their meals and also depend on charity food in absence of opportunity to cook their meals
6) Dependent on family- The respondents who are dependent on their family members (not earning/ infirm)
7) Charity- The respondents who are totally dependent on charity food.
8) Blanks- There were few respondents who were unable to speak (due to disability); and some who had left after taking their weight, height measurement and hence dietary recall were not done for these respondents.

The table below shows the number and percentage of people in each category of source of food:

Table 1: Source of food

	No. of people	%	No. of female	%	No. of male	%
Purchased food	102	54	27	38	75	63
Purchased & charity	33	17	13	18	20	17
Purchased & cooked	3	2	1	1	2	2
Cooked	26	14	17	24	9	8
Cooked & charity	1	1	0	0	1	1
Dependent on family	3	2	3	4	0	0
Charity	7	4	5	7	3	3
Blanks	15	8	6	8	9	8

More than half the people purchased cooked food i.e. 54% while only 4 % depended on charity. Those who depended on charity for meals also had out-of-pocket expenses for the first meal of the day (breakfast – tea and cereal based snacks with minimal oil). The 54% of people depending on 'Purchased food' spent Rs. 59 per day on food against an earning of Rs. 107 per day which is 55% of their total earnings.

It is seen that people depending sporadically on charity are also not able to reduce their spending on food. An average of Rs. 19 is spent by those purchasing their food as well as depending on charity as against their daily income of Rs. 42, which also is almost half of their earnings (this was the response from 15 respondents belonging to this category, 16 respondents in this category did not have any income at all for the previous day along with 2 blanks). One can however see that the people spending sporadically on charity also have their income correspondingly lower than those not depending on charity food at all. Thus correspondingly, those depending solely on charity food also had no income at all. On computing income for all male and all female respondents it was found that the average income of the male respondent was Rs. 104 and for female respondents was Rs. 53 - both of which is way below the prescribed minimum daily wage.

Why not eat in a langar like the others?
"I don't eat from there…"

You don't eat free food even if it means not eating?
"I don't ever…"

In all, 50 respondents i.e. 26% of the total; reported an expenditure on food despite having no earnings at all. Those depending on solely on charity were not significantly different from the rest in terms of age. It might be significant to point that none from the MCD shelter where single working men were staying depend on charity for their dietary intake. Those depending on charity did not have any earnings recorded (two entries blank, rest zero).

- People spending sporadically on charity also have their income correspondingly lower than those not depending on charity at all
- People depending solely on charity has no income at all
- Average income of male and female respondents was lower than the prescribed minimum daily wage (Rs. 104 and Rs. 53 respectively)
- None from the MCD shelter were depending on charity for their dietary intake
- 50 respondents i.e. 26% of the total; reported an expenditure on food despite having no earnings at all.

b) Dietary intake: Quantity and quality

The meal intake per day is shown in the table below in numbers as well as percentages (Table 2):

Table 2: Intake of Meals per day

	No. of people	% of people	Female Nos.	Female %	Male Nos.	Male %
3 Meals	105	61	36	56	69	64
2 Meals +tea	18	10	8	13	10	9
2 Meals	45	26	20	31	25	23
1 Meal +tea	1	1	0	0	1	1
1 Meal	3	2	0	0	3	3

"I went hungry. Did not eat last night… because of the storm. We **(she and her children)** ***were running to find shelter"***
- a woman staying in a park in Nizamuddin

Here also, the number of people belonging to the category of those who have taken 3 meals is the highest. The category of '2 meals + tea' are the respondents who take only tea as the first meal of the day (breakfast). There is also an absolute lack of intake of fruits in the diets, only 4 respondents in all reported taking fruits, two respondents taking bananas and 1 taking grapes and 1 taking 4 oranges. The later was a fruit seller. Only two respondents taking milk, one instance in this is of a woman taking half roti and milk as her food (for the entire day). Barring 27 respondents all take tea, in which though the content of milk may be minimal at least some sugar intake for the day is ensured.

The dietary intake was clubbed into the following categories to understand the quality of the intake. Thus the food intake was divided into - Tea, cereal based snacks, cereals (grains), vegetables- potatoes, green leafy and others, pulses, milk, meat and eggs fruits and others. Breakfast for most consist of tea and cereal based baked snacks- puff without filings and fann, a crispy oil and cereal based snack. The other meals- lunch and dinner consist of roti or rice, vegetables which is predominantly consist of a potato base along with a vegetable (cauliflower/ tomatoes/ spinach/ peas/ cabbage) or just potatoes. Dal also forms a part of the diet, however one cannot come to consistency of the dal. Intake of fruits was minimal, only 3 respondent in all reported taking fruits in the previous days' diet (One of the three respondents was a fruit seller). Intake of milk was reported by only two participants. There were however some content of meat (39 respondents) in

the diet. There was an absolute lack of milk (4 respondents) and fruits (3 respondents). A significant number of respondents (149) show intake of tea.

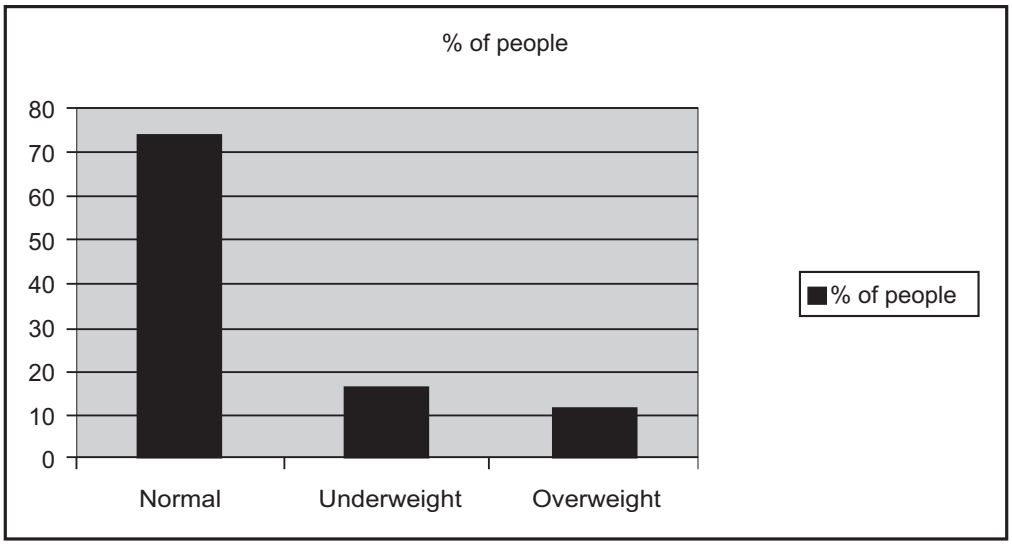
- There is an absolute lack of fruits and milk in the diet of the respondents
- Breakfast for most consist of tea and cereal based snack- (puff without fillings or fann)
- Vegetable intake is mostly potatoes (42 respondents, 22%)

c) BMI Status of homeless adults

The nutritional status of the respondents was recorded on the basis of height and weight measurements (to compute a Body Mass Index) and observation of prevalence of anemia. However, due to the setting of the study (interviews with homeless populations mostly accessible only at night after working hours on streets and in dimly lit temporary shelters), it was difficult to observe the anemia in the community situation. While the observation of anemia was initially recorded, later it had to be given up since we were losing daylight. Therefore only the height and weight was measured for adults. After computing the BMI it was compared with the international classification table as given by the WHO, it was found that 47 female (65%) and 92 males (78%) (Refer to Table 4) were of normal BMI (139 in all).

Table 3: BMI of the respondents

	All	% of total respondents
Normal	139	73
Underweight	30	16
Overweight	21	11



The desegregation of the above data for male and female is shown:

Table 4: BMI Male/ Female

	Female (Nos.)	(%)	Male (Nos.)	(%)
Normal	47	65	92	78
Underweight	12	17	18	15
Overweight	13	18	8	7
Total	72	100	118	100

65% of all women, i.e. 47 out of a total of 72 women were in the normal category and 78% of all men i.e. 92 out of 118 were in the normal category. 12 female and 18 males were found to be underweight (17% of all women and 15% of all men). There were more overweight women (18% of all women) than men (7% of all men).

Among the respondents there were more overweight women than underweight women. In both the categories of overweight and underweight, the number of women were more than that of man.

Comparing the BMIs of respondents from the AAA shelter (NGO run shelter) (5 underweight out of 14 respondents) and MCD shelter (2 underweight out of 29 respondents) significantly more number of underweight adults are present in the AAA shelter (p-value 0.022).

- More than 50% of all women and all men belonged to the Normal category of BMI classification.
- In both the categories of BMI classification –overweight and underweight –there are women than men
- There were more underweight in the AAA shelter as compared to the MCD shelter

Main findings

The major findings could be pointed out as follows:

- People depending solely on charity had no income
- People depending sporadically on charity had less income then those who only purchased cooked meals
- Single working male living in the MCD night shelter did not depend on charity for food
- People who did not have any earnings the previous day also recorded spending on food (26%, i.e. 50 respondents)
- Absolute lack of fruits and milk in the diet (only three persons had fruits in their diet and only four persons had milk in their diet). No protective food in the diet.
- The intake of vegetables predominantly consists of potatoes.
- More than 50% of all women and all men belonged to the Normal category of BMI classification.
- In both the categories of BMI classification –overweight and underweight –there are women than men
- There is a significantly more number of underweight in AAA night shelter as compared to MCD night shelter (Nizamuddin).
- The average income of the people was below the prescribed minimum daily wage.
- The income of the women was substantially lower than that of the men, on computation women earn 50% less than men.

Discussion

The sample for the study – 190 homeless adults at Nizamuddin and Okhla is inherently representative of more young working homeless men as compared to any other category of homeless persons. The study initially attempted to get a sample of 100 men and 100 women. Based on secondary data sources about area wise population of homeless in Delhi (IGSSS, 2009), we speculated that at the chosen two areas – Nizamuddin and Okhla – we would be likely to find more homeless women as compared to other areas of Delhi due to greater homeless family settlements and shelters for both men and women. However, the final study sample had 62% male population (118) and only 38% female population (72).[7] There were several reasons for this. Apart from the streets itself, the sample was selected from shelters for the homeless. However, shelters do not seem to be perceived as safe spaces to access for homeless women. E.g. At Nizamuddin, one of the night shelter (MCD) though being a shelter for both men and women was inhabited only by working men. Thus the choice of location for the sample led to less women being represented in the sample. Furthermore, field investigators noted that many of the women on the streets were busy with daily chores such as cooking, caretaking of children and therefore more reluctant to come for the survey. Finally, it is found that single men constitute a significant 86.6% proportion of the homeless populations in Delhi, irrespective of areawise population (IGSSS, 2009).

It must also be pointed out that the homeless populations at Nizamuddin and Okhla areas are not necessarily representative of the entire homeless population in Delhi. Earlier research shows that most of the homeless are concentrated in and around Old Delhi and Walled City areas of Delhi (IGSSS, 2009). Therefore, this data is likely to be region specific.

A significant reason for the greater proportion of homeless persons within normal BMI range could be that the average age of the respondents was 36 years. The other trend of more women with undernutrition as well as obesity corresponds with the findings of NHFS III.

The sample of the study has inherently represented the nutritional status of homeless adults who are mostly in the young productive years of their life cycle, while under representing the nutritional status of more vulnerable categories such as the elderly and children, who are more susceptible malnutrition. This younger, and mostly male category of working homeless persons are more likely to spend most of what they earn on keeping fit due to a consciousness to remain healthy in order to be able to be more physically productive and consequently to be able to work and earn more. This study clearly points toward the fact that 54% of the respondents purchased food. It has been reported that homeless persons prefer to purchase food as opposed to cooking or depending on charity. While cooking is time consuming in itself, charity food forces the persons to be dependent on the timing, menu and availability of food at religious places. All of this puts

[7] This sample is comparable with respect to gender ratios of samples used in earlier studies such as IGSSS (2009) which used a 60% adult male, 15% adult female and 25 % children sample.

constraints on the number of work hours of urban homeless people; many of whom are casual workers for whom reaching the job market early in the morning is imperative for getting labour for the day (Mander et al, 2008). Even within this category of persons who purchase food, the average daily expenditure was found to be over 55% of their daily income. Earlier studies have pointed towards even higher trends of – majority of the respondents spend 50 – 80% of their daily income on food (Mander et al, 2008).

The 'survival of the fittest' principle is the norm of the life on the streets. While most of the homeless are migrants, it needs to be noted that usually in families, it is the healthier persons who move out of their homes in an effort to earn for themselves and their families. The longer the period of homelessness the person has survived, the more the number of coping strategies the person may have found to battle food deprivation and hunger in life on the streets. It is an inherent assumption, therefore, that most of the current respondents of the study are 'survivors' who have found their means to cope as opposed to the many homeless persons who have lost and continue their lives in this battle to starvation. This is evident from the fact that the Supreme Court Commissioners have therefore used this assumption and quoted *"Any death occurring on the streets and any unclaimed body, not resulting from an accident, must be treated as a possible starvation death unless proved otherwise and stringent punitive action taken for the same along with compensation to next of kin."* (Letter by Commissioners to Supreme Court, 22 January 2010). Mortality rates amongst the homeless may be very high but are currently unknown.

Looking at their dietary intake one could comment that their intake is mostly of carbohydrates (rice or roti) and the most common vegetable in their diet is potatoes which is also carbohydrate. The pattern of dietary intake corresponds to an earlier study done by National Nutrition Monitoring Bureau[8] wherein the diet of the urban poor was stated to be lacking in protective foods[9] such as pulses, leafy and other vegetables, milk, fruits, (good) fats and oils. There seem to be a fairly good number of people (39 respondents) with intake of meat, however it needs further investigation to inquire if this could be a significant source of protein as the meat intake usually consists of shred of chicken in the biryani.

The MCD shelter is a permanent one whereas the AAA is not. The MCD shelter does not allow chemical dependents- drugs, alcohol to be admitted though this is an agreement amongst those who stay there and not an officially stated rule as such. On the AAA shelter is there is no prohibition on use of alcohol, smack. One could therefore presume a certain set of people would prefer one shelter over another which might lead to the different shelter showing a particular pattern in the BMI (AAA shelter shows more underweight men than MCD shelter).

It is to be noted, comparing the dietary intake, BMIs and the number of meals that people do fall in the normal range of BMI, take their three meals a day and manage to work to earn their livelihood, however this

[8] As quoted in an NIN publication, "Nutritive Value of Indian Foods", 2004 (Reprint)

[9] Protective foods are the foods that provides one with vitamins and minerals, so called as it help the body to produce substance which prevent us from bodily harm (Lesson 4: Protective food http://directory.wikieducator.org/Lesson_4:_Protective_Foods)

needs to be juxtaposed with the situation of homelessness and their earnings. As seen people do spend more than half of their income to maintain their normal range of BMI, eat their three meals a day to keep working as a non working day would mean a non-eating day the next day or a few more days till their meagre savings run out. It can also be suggested that living in the streets require much more hardiness and thus we might not have come in contact with many in more dire straits- disabled/ starving/ people with mental illnesses and/or in transit. It has also to be seen in the context of preventing an exit from homelessness even for young adult population who are working – who anecdotally desire to lead a different life. Our findings also counter notions that the homeless do not have a commitment towards their own health and well being. Also the myth that homeless are lazy, careless and want to eat for free remains a myth as shown by the study that only a few people access charity food and fewer still depend on it as the sole means to address their dietary requirements. Single working men living in the shelter do not use charity food at all.

Conclusion and Recommendation

It could be seen that most of the respondents were conscious of keeping themselves fit and were able to maintain their BMI albeit compromising on everything else –living without earnings/ state of homelessness. It could be seen that the present situation of the maintaining their health demands the state of homelessness, a situation from which they would be unable to exit unless provisions of food subsidies are made for them. There is thus a need to assist people to exit homelessness. There is a dearth of more participative study to enquire on the needs of the homeless and most particularly that of women living in the streets. More participatory exercises are thus required before embarking on a scheme to counter the state of food insecurity.

Currently there is a lack of government initiatives to combat food insecurity. The sole exception to this could be the 'Aap ki Rasoi' programme which is a hunger-free programme run by the Delhi government jointly with the Akshaya Patra Foundation (APF), The programme is an innovative initiative under the Bhagidari scheme of the Delhi government intends to ensure at least one full time meal to the homeless and the destitute. Currently the reach of the programme is 3000 people in the city which is quite minimal compared to the conservative approximation of 1. 5 lakhs homeless in the city.

The intervention that one would be currently looking for is a non charity based, nutritional balanced subsidized food programme that would serve hot cooked meals (breakfast and dinner) twice a day (subsidized @ Rs 15/- per meal) accessible to all, especially women. However there is still a need to engaged with the homeless to enquire upon issues of dignity, sites of distribution of food, choice of food, the need to further subsidized for more vulnerable groups etc. This would allow the many homeless people who are struggling to maintain themselves and often families at home to have some chance of saving enough to be able to make a substantial shift away from homelessness.

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Public Health Resource Network (PHRN) seeks to identify like-minded, motivated individuals and organisations through existing state level resource support agencies, NGO networks and state health societies, and reach out to them in order to accelerate and consolidate the potential gains from the National Rural Health Mission that can truly change the health scenario of disadvantaged people. PHRN has been active since 2005 in the states of Chhattisgarh, Jharkhand, Bihar, and Orissa. It has also supported similar action in many other states, such as Rajasthan, Haryana, Uttarakhand and the North Eastern states. PHRN believes in refining its objectives and strategies in accordance with its experience as well as circumstances of its work.

Centre for Equity Studies (CES), founded in August 2000, is an autonomous institution engaged in research and advocacy on issues of social justice. It seeks to enquire into the nature and causes of social injustice and inequity and to collectively find methods of moving towards a more equitable world. CES conducts research on hunger and social exclusion and also serves to advise the Office of the Commissioners to the Supreme Court in the Right to Food case. Furthermore, CES initiated the Dil Se campaign – a right based campaign focused on creating a model of state action to secure the rights of all homeless children. Apart from this, CES conducts research and advocacy on issues of communal violence and homelessness.